SECTION 1

GENERAL

1.0. PURPOSE OF APPEAL PROCESS

This attachment describes the appeals and hearings process as tailored for the TRICARE Retail Pharmacy (TRRx) contract. For the purposes of the TRRx contract, appealable issues include: medical necessity denials, denials based on factual (coverage) issues, and provider sanctions. The right to appeal may arise as a result of the processing of a claim, the denial of a request for prior authorization or the sanctioning of a provider. Flow charts diagramming the appeal process relating to denials are included in Addendum A, Figures A-5 and A-6. An appeal under TRICARE is an administrative review of program determinations made under the provisions of law and regulation. An appeal cannot challenge the propriety, equity, or legality of any provision of law or regulation. This attachment sets forth the policies and procedures for appealing decisions made by the TRRx contractor that adversely affect the rights and liabilities of beneficiaries and network pharmacies.

1.1. Medical Necessity Denials

"Medical necessity" is considered a collective term for determinations based on medical necessity (as this term is defined in 32 CFR 199.2) or other reason relative solely to reasonableness, necessity or appropriateness. A determination that the pharmaceuticals or supplies furnished or proposed to be furnished to a patient are not medically necessary is an initial denial determination and is appealable. Examples of medical necessity determinations include: (1) whether medical necessity substantiates providing a beneficiary a non-formulary pharmaceutical or supply at the formulary co-pay; and (2) where prior authorization is required for a designated pharmaceutical, whether supporting documentation supports authorization of the pharmaceutical.

1.2. Factual (Coverage) Denials

Denial determinations based on coverage limitations contained in 32 CFR 199, the TRICARE Policy Manual, and other TRICARE guidance, are considered factual determinations. Examples of factual denials include denial of claims or prior authorization requests for Viagra (over the quantity authorized by the policy manual), weight loss pharmaceuticals (as these are not a benefit under TRICARE) and pharmaceuticals unproven for the patient's diagnosis.

1.3. Provider Sanctions

The contractor is required to implement a Fraud and Abuse Detection Plan. Providers found to have committed fraud or abuse are subject to the sanctions set forth in 32 CFR 199.9. Under 32 CFR 199.10(c) and (d), an initial determination issued by the contractor

sanctioning a provider is appealed directly to a hearing conducted by the TMA Appeals and Hearings Division.

2.0. AUTHORITY

Title 32, Code of Federal Regulations (CFR), Part 199 authorizes the appeal process. The procedures and principles included in this attachment are based on the requirements of 32 CFR 199.10 and 32 CFR 199.15. Attachment 12 is tailored for the TRRx contract and includes the provisions of 32 CFR 199.10 and 32 CFR 199.15 that are applicable to the TRRx program.

3.0. CONTRACTOR RESPONSIBILITIES

It is the responsibility of the contractor to ensure that the rights of appealing parties are protected at all levels of the appeal process in which the contractor participates. The contractor's responsibility begins with the initial determination and does not end until a final resolution is reached, including, where appropriate, timely payment for or authorization of pharmaceuticals or supplies following a reversal.

3.1. Initial Determinations

The contractor shall develop a written plan and implement a formal appeal process that provides for appeal of denials of prior authorizations for pharmaceutical agents, medical necessity denials, denials based on coverage issues and provider sanctions. The contractor shall issue a dated initial determination in the form of a letter. The initial determination shall contain sufficient information to enable the beneficiary or provider to understand the basis for the denial. The initial determination shall state with specificity what pharmaceutical or supply is being denied and for what reason. The contractor shall retain a legible hardcopy or microcopy of the initial determination or be able to produce a duplicate letter from electronic records upon request. The initial determination shall include adequate notice of appeal rights and requirements. If a request for prior authorization for a pharmaceutical or supply is denied and a claim is later submitted for the pharmaceutical or supply, both the denial of authorization and the claim denial are considered initial determinations and, therefore, either may be appealed. A suggested notice is at paragraph 3.2.1 below.

3.2. Written Notice Of Initial Determination

3.2.1. Suggested wording for a nonexpedited written appeal notice in cases involving medical necessity and coverage denials:

> "You as [insert either "the TRICARE beneficiary, or "a network pharmacy that has been sanctioned"], or your appointed representative, have the right to request a reconsideration. The request must be in writing, must be signed, and must be postmarked or received by [insert name of contractor, postal address, e-mail address, and fax number]] within 90 calendar days from the date of this decision and must include a copy of this decision. Additional documentation in support of the appeal may be submitted; however, because the request for reconsideration must be postmarked or received within 90 calendar days from the date of this decision, the

request for reconsideration should not be delayed pending the acquisition of additional documentation. If additional documentation is to be submitted at a later date, the letter requesting the reconsideration must include a statement that additional documentation will be submitted and the expected date of submission. Upon receiving your request, all TRICARE claims related to the entire course of treatment will be reviewed."

3.3. *UNDELIVERABLE INITIAL DETERMINATIONS*

If the notice of initial determination is returned as undeliverable, the contractor shall void any check issued in connection with an approved claim.

3.4. *Submission Of Reconsideration Requests*

The contractor shall establish unique post office boxes or addresses for submission of reconsideration requests.

4.0. *FINALITY OF INITIAL DETERMINATION*

The initial determination is final and binding unless the initial determination is reopened by the contractor or revised upon appeal.

5.0. *PROVIDING ASSISTANCE*

5.1. *To Appealing Parties*

The contractor shall ensure that the rights of appealing parties are protected. In discharging this responsibility, the contractor shall:

- Issue initial and reconsideration determinations which clearly explain appeal rights when an adverse decision is made.
- Explain to inquirers the procedures for requesting a reconsideration, a formal review or a hearing.
- Complete the file documentation when necessary, e.g., develop for additional information when the appealing party's statements indicate a need for added support or the file indicates added development is appropriate.
- When requested to do so, provide the appealing party a copy of the appeal file.
- When requested to do so, afford the appealing party a reasonable period of time to submit additional documentation.

5.2. *To the National Quality Monitoring Contractor (NQMC)*

When an appealing party files for a reconsideration with the NQMC, upon request of the NQMC, the contractor shall provide a complete file record to the NQMC by overnight mail or facsimile (fax).

5.3. *To The TRICARE Management Activity (TMA)*

When an appealing party files for a formal review or hearing with TMA, the contractor shall provide a complete file record to TMA on a timely basis. (See Section 4for requirements.)

6.0. *REPROCESSING OF CLAIMS AND PRIOR AUTHORIZATION REQUESTS FOLLOWING ISSUANCE OF RECONSIDERATION DETERMINATIONS, FORMAL REVIEW DETERMINATIONS AND HEARING FINAL DECISIONS*

TMA will provide the contractor with a copy of the formal review determination and hearing final decision. All contractor determinations reversed in whole or in part by the contractor's or the National Quality Monitoring Contractor's (NQMC's) reconsideration determination, the TMA formal review determination, or by a hearing final decision, shall be reprocessed by the contractor within 21 calendar days of the date of receipt. The date of receipt is considered the date the NQMC's reconsideration determination, the formal review determination or the hearing final decision is received by the contractor.

7.0. *QUALITY OF CONTRACTOR APPEALS PLAN*

The contractor shall include in its Quality Assurance Plan a process that will identify areas for improvement in the appeals process, implement changes to the appeals process, and measure the successes or failures of the changes implemented.

8.0. *TIMELINESS OF CONTRACTOR RECONSIDERATION DETERMINATIONS*

Timeliness of contractor reconsideration determinations is addressed in Sections 3, paragraph 3.4.

9.0. *PHARMACEUTICALS AND SUPPLIES AUTHORIZED IN ERROR*

If a contractor authorizes pharmaceuticals or supplies, and the beneficiary obtains the pharmaceuticals or supplies in reliance on the authorization, and the pharmaceuticals or supplies are later determined not to be a benefit under TRICARE, appropriate recoupment action shall be taken in accordance with Section J, Attachment 3.

10.0. *DOCUMENTATION*

The contractor shall deliver to TMA, Appeals and Hearings Division, one complete set of its processing guidelines, desk instructions, and reference materials covering all tasks required in Attachment 12, no later than 60 calendar days prior to the start of health care delivery.

SECTION 2

GOVERNING PRINCIPLES

11.0. APPEALING PARTY

11.1. Proper Appealing Party

Parties that may appeal are limited to TRICARE beneficiaries (including minors), or a network pharmacy that has been terminated, excluded, suspended, or otherwise sanctioned.

11.2. Appeals From More Than One Party

An appeal may be accepted from more than one proper appealing party. If more than one party appeals, the contractor shall mail separately addressed appeal determination letters to each appealing party (or representative, if a representative has been appointed).

11.3. Appealing Party/Representative

11.3.1. Appeals On One's Own Behalf

An appealing party is entitled to file an appeal on his or her own behalf.

11.3.2. Minors And Incompetent Beneficiaries As Appealing Parties

11.3.2.1. A minor beneficiary is a proper appealing party.

11.3.2.2. Generally, the custodial parent of a minor beneficiary and the legally appointed guardian of an incompetent or minor beneficiary shall be presumed to have been appointed representative without specific designation by the beneficiary. The parent of a minor beneficiary shall be presumed to be the custodial parent unless there is evidence to the contrary. If a parent or guardian is pursuing the appeal on behalf of a minor beneficiary and the minor reaches 18 years of age during the appeal, the parent or guardian will be presumed to be authorized to continue the appeal on behalf of the beneficiary unless the beneficiary provides a written statement of his or her desire to pursue the appeal in his or her own behalf, in which case the appeal decision will be mailed to the beneficiary. Once the contractor issues the appeal determination, the beneficiary who reached 18 years of age during the appeal must request all subsequent levels of appeal or appoint a representative to do so. (Refer to paragraph 11.3.3.1. below for additional information relating to parents and guardians as representatives.)

11.3.3. Representative

If the proper appealing party cannot or does not wish to pursue the appeal personally, or wishes to have another person directly assist in pursuing an appeal, the appealing party may appoint a representative to act in his or her behalf at any level of the

appeal process. With the exception of network and uniformed providers, the appointment of a representative must be in writing and must be signed by the proper appealing party or an individual must be appointed to act as representative by a court of competent jurisdiction.

11.3.3.1. Parents Or Guardians As Representatives

The sponsor or custodial parent of a beneficiary under 18 years of age or the guardian of an incompetent beneficiary cannot be an appealing party; however, such persons may represent the appealing party in an appeal. The custodial parent of a minor beneficiary and the legally appointed guardian of an incompetent beneficiary shall be presumed to have been appointed representative without specific designation by the beneficiary; however, this presumption shall not apply if the claim was signed by a minor and the claim is related to abortion, alcoholism, substance abuse, venereal disease, or AIDS. (Refer to paragraph 11.3.2. above for additional information relating to minors as appealing parties.) A suggested format for "Appointment of Representative and Authorization to Disclose Information" is included in Addendum A, Figure A-1.

11.3.3.2. Conflict Of Interest

To avoid possible conflict of interest, an officer or employee of the United States, such as an employee or member of a Uniformed Service, including an employee or staff member of a Uniformed Service legal office, or a Health Benefits Advisor, subject to the exceptions in Title 18, United States Code, Section 205, is not eligible to serve as a representative. An exception usually is made for an employee or member of a Uniformed Service who represents an immediate family member and for a uniformed provider.

11.3.4. Appeal Filed By Attorney

If an attorney files an appeal on behalf of a proper appealing party, the contractor shall assume, absent any evidence to the contrary, that the attorney has been duly authorized to act as the appealing party's representative in the appeal. Care shall be taken to ensure that the attorney is representing a proper appealing party (e.g., an appeal filed by an attorney as the representative of the spouse of a beneficiary, or parent of an adult beneficiary, shall not be accepted).

11.3.5. Appeal Filed For Deceased Beneficiary

An appeal may be filed for a deceased beneficiary by a person authorized to sign TRICARE claims on behalf of the deceased beneficiary in accordance with the following provisions:

11.3.5.1. If the provider of care has an approved signature on file agreement and the beneficiary expires, the authorization for payment will satisfy the signature requirements and the contractor shall process the claim.

11.3.5.2. If the beneficiary is deceased, the claim form must be signed by the legal representative of the estate. Documentation must accompany the claim form to show that the person signing is the legally appointed representative. If no legal representative has been appointed, the claim form may be signed by the parent, the spouse, or the next of kin. The signer must provide a statement that no legal representative has been appointed. The

statement should contain the date of the beneficiary's death and the signer's relationship to the beneficiary to enable the contractor to update the history file.

11.3.5.3. In the event that there is no spouse, parent or guardian to sign the claim form for a deceased beneficiary, the claim must be signed by the surviving next of kin or a legally appointed representative (indicate relationship to beneficiary).

11.3.6. Inquiries Made By Members Of Congress On Behalf Of Beneficiaries

Inquiries submitted by Members of Congress regarding a specific appealing party's claim or claims are not considered requests for a reconsideration. If the letter from the Member of Congress is postmarked or received by the contractor before the expiration of the appeal filing deadline and is accompanied by a letter from the appealing party which meets the requirements of a request for reconsideration, the appealing party's letter to the Member of Congress may be accepted as an appeal. The Member of Congress and the appealing party shall be advised that a reconsideration will be conducted and that the appealing party will be notified of the results. If the congressional inquiry is not accompanied by a letter from the appealing party which contains all the elements of a request for a reconsideration, the contractor shall explain the procedure for filing an appeal so that the Member of Congress may advise the appealing party. Response to Congressional inquiries are subject to the provisions of the Privacy Act of 1974. Once an appeal has been accepted, the contractor may tell a Member of Congress inquiring on behalf of an appealing party only that an appeal has been filed and that it would be inappropriate for the contractor to comment on the case unless the appealing party has authorized the Member of Congress, in writing, to receive information on behalf of the beneficiary.

11.4. Sanctioned Pharmacies

A network pharmacy that has been sanctioned by TRICARE is entitled to appeal the initial determination made by either the contractor or TMA. When the denial is based on the exclusion of the pharmacy by another Federal or Federally funded program, e.g., Medicare or Medicaid, because of fraud or abuse, the issue is not appealable through the TRICARE appeal system. Sanctioned pharmacies denied approval are deemed to have met any required amount in dispute at all levels of appeal.

12.0. APPEAL PROCESSING JURISDICTION

Appeals may be received involving more than one jurisdiction. For example, a case may involve pharmaceuticals or supplies processed by both the outgoing contractor and the incoming contractor in a period of transition and will require separate review. The contractor receiving the appeal shall notify the appealing party that the pharmaceuticals or supplies will be reviewed separately by the outgoing contractor and the incoming contractor. The notification shall also include the name and address of each contractor performing the reviews. The contractor shall photocopy the written appeal request, the notification to the appealing party of the referral, and other relevant information and forward the photocopies to the other contractor with an explanation of the action taken within 21 calendar days of the stamped date of receipt of the appeal in the mailroom.

13.0. APPEAL REQUIREMENTS

For all appeals at all levels:

13.1. Must Be Filed In A Timely Manner

The appealing party must comply with the "allowed time to file" requirements included in Section 3, paragraph 1.4.

13.2. Must Be An Appealable Issue

There must be a disputed question of fact which, if resolved in favor of the appealing party, would result in an extension of TRICARE benefits or reinstatement of a sanctioned pharmacy. Non-appealable issues are limited to the issues listed in Section 3, paragraph 1.3.2.

13.3. Must Be An Amount In Dispute

There must be an amount in dispute before an appeal can be accepted (see paragraph 14.0.). This involves the following requirements:

- In a case involving an appeal of denial of authorization in advance of purchase of pharmaceuticals or supplies, the amount in dispute will be the estimated allowable charge for the pharmaceuticals or supplies requested.
- There must be a legal obligation on the part of the beneficiary, parent, guardian, or sponsor to pay for the pharmaceuticals or supplies.
- Payment or authorization of TRICARE benefits for the pharmaceutical or supply must have been denied in whole or in part.

13.4. Must Be A Proper Appealing Party

See paragraph 1.1.

13.5. Must Be In Writing

All appeal requests must be in writing and submitted by a proper appealing party. A signature is not required if a determination can be made that the request was submitted by a proper appealing party. If it cannot be determined that the appeal request was submitted by a proper appealing party, the proper appealing party shall be instructed by the contractor that a signed appeal, must be filed within 20 calendar days of the contractor's letter or by the appeal filing deadline, whichever is later. A verbal request for a reconsideration cannot be accepted. When telephone calls are received or personal visits occur which relate to an adverse initial determination, the contractor shall make every effort to satisfy the inquirer's complaint, inquiry, or question, including advising the inquirer of his or her right to appeal, if applicable.

14.0. AMOUNT IN DISPUTE

An amount in dispute is required for an adverse determination to be appealable. Although some amount must be in dispute for a reconsideration, unless specifically waived, there is no established minimum dollar amount. Fifty dollars or more shall be in dispute for a formal review request to be accepted at TMA. Three hundred dollars or more shall be in dispute for the case to be accepted as a hearing. The requirement for an amount in dispute does not preclude a beneficiary from appealing a prior authorization denial determination, as set forth in paragraph 4.1.2., nor does it preclude a network pharmacy from appealing a determination by TMA to terminate, exclude, suspend or otherwise sanction the pharmacy. The determination of "amount in dispute" affects the appealing party's rights and must be carefully evaluated, including, when appropriate, multiple claims for the same pharmaceuticals or supplies and related claims.

14.1. Calculating The Amount In Dispute

The "amount in dispute" is calculated as the actual amount the contractor would pay if the pharmaceuticals or supplies involved in the dispute were determined to be payable.

14.1.1. Examples Of Excluded Amounts

EXAMPLE 1: Amounts in excess of the TRICARE-determined allowable charge or cost are excluded.

EXAMPLE 2: The beneficiary's TRICARE deductible and cost-share amounts are excluded.

EXAMPLE 3: Amounts which the TRICARE beneficiary, parent, guardian, or other responsible person has no legal obligation to pay are excluded.

14.1.2. Amounts For Prior Authorization Appeals

When the dispute involves denial of a request for authorization in advance of receiving the pharmaceuticals or supplies, the amount in dispute shall be the estimated allowable charge or cost for the pharmaceuticals or supplies requested for the effective period of the prior authorization, e.g., the costs of a prescription written for a maintenance drug that requires monthly refills is considered a single dollar amount within the effective period of the prior authorization for purposes of meeting the amount in dispute requirement.

14.2. Related Claims

When the contractor receives an appeal on a claim which has been denied, the contractor shall retrieve and examine all previous claims submitted for the same or similar pharmaceuticals or supplies being denied payment or authorization to determine if the claim in dispute was properly denied and if previous claims were properly processed. All related claims shall be made part of the appeal file. The file shall contain full documentation pertaining to the pharmaceutical or supply in dispute, to include a record of actions taken by the contractor on all claims involving the same pharmaceutical or supply. If the contractor determines that previous claims have been incorrectly paid, the contractor shall follow the procedures in Section 4.3. below.

14.3. Erroneous Payments

In considering an issue under appeal, questions may arise concerning previous payment of pharmaceutical or supply claims not under appeal. Possible erroneous payments will be reviewed in depth, including medical review if necessary, to determine if, at the time the initial determination was made, there existed any basis for the payment. If the reviewer concludes there was a basis for payment at the time the claim was processed, the payment may stand. When the evidence indicates a payment was erroneous and not supported by law or regulation, and an appealable issue exists, the following action will be taken.

14.3.1. Recoupment Involving Separate Issues

The contractor may request a refund and treat the recoupment action as an initial determination. Appeal rights shall be offered to the next level of appeal. Any new appeal must address itself to the benefit issue in dispute and not the fact that a refund has been requested.

14.3.2. Recoupment Involving Issues Under Appeal

When the contractor examines claims which are related to the claim in dispute and determines that one or more of the related claims were improperly paid, the contractor shall explain the erroneous payment in detail and advise the appealing party of any recoupment. If the contractor determines recoupment is appropriate, the amount of the erroneously paid claim(s) will be added to the amount in dispute, and the reconsideration review will consider both the claim(s) in dispute and the erroneously paid related claim(s) which involve the same issue. If the total amount in dispute permits a higher level appeal, the appealing party will be so advised.

SECTION 3

RECONSIDERATION PROCEDURES

15.0. REQUIREMENTS FOR REQUESTING A RECONSIDERATION

15.1. Must Be In Writing

15.2. Must Be Made By A Proper Appealing Party

If the contractor receives a timely appeal request for reconsideration from a person who is not authorized to participate in the appeal, before the expiration of the appeal filing deadline, the contractor shall treat the request as routine correspondence, and add the request to the claim file. The contractor shall advise the proper appealing party in writing (see Addendum A, Figure A-4) with a copy to the improper appealing party. A blank "Appointment of Representative," form shall be enclosed with the letter to the proper appealing party (see Addendum A, Figure A-1). The proper appealing party shall be told that an appeal must be filed within 20 calendar days of the date of the contractor's letter or by the expiration of the appeal filing deadline, whichever is the later.

15.3. Must Include An Appealable Issue

15.3.1. Appealable Issues

15.3.1.1. A TRICARE beneficiary making use of the prior authorization process who requests prior authorization to receive a pharmaceutical or supply and such prior authorization is denied by the contractor, may appeal even though no pharmaceutical or supply has been provided and no claim submitted. (Refer to paragraph 6.2. below for additional information relating to prior authorization denials).

15.3.2. Non-appealable Issues

The following issues are not appealable and shall not be accepted for reconsideration. They should be counted as correspondence for both workload report and processing purposes.

15.3.2.1. Allowable Charge

The amount of the TRICARE-determined allowable cost or charge for a pharmaceutical or supply is not appealable, since the methodology for determining allowable costs or charges is established by regulation.

15.3.2.2. Eligibility

Determination of a person's eligibility as a TRICARE beneficiary is not appealable since this determination is the responsibility of the Uniformed Services.

15.3.2.3. Provider Sanction

The decision to disqualify or exclude a pharmacy because of a determination against that pharmacy resulting from abuse or fraudulent practices or procedures under another federal or federally-funded program is not appealable. The provider is limited to exhausting administrative appeal rights offered under the federal or federally-funded program that made the initial determination. However, a determination to sanction a provider because of abuse or fraudulent practices or procedures under TRICARE is an initial determination which is made by the contractor and is appealable under 32 CFR 199. A sanction imposed pursuant to 32 CFR 199.15(m) is appealable as described in 32 CFR 199.15(m)(3).

15.3.2.4. Provider Not Authorized

The denial of a pharmaceutical or supply received from a provider not authorized to provide pharmaceuticals or supplies under TRICARE is not appealable.

15.4. Must Be Filed Timely

An appeal must be filed by the appealing party within 90 calendar days after the date of the initial denial determination, or within 20 calendar days of the date of the contractor's letter, referenced in paragraph 1.2. above. In calculating the number of days elapsed, the day following the date of the previous determination is counted as day "one" with the count progressing through actual calendar days including the date the request is filed. The contractor shall treat an untimely request for reconsideration as routine correspondence, and add the request to the claim file.

15.4.1. By Mail

If the appeal is not filed timely, the contractor shall advise the appealing party that the appeal cannot be accepted since the time limit for filing was exceeded, based on the receipt date of the appeal request or the postmark date on the envelope. For the purposes of TRICARE, a postmark is a cancellation mark issued by the United States Postal Service (i.e., private mail carriers do not issue postmarks). If there is no postmark or the date of the postmark is illegible, the date of receipt by the contractor shall be used to determine timeliness of filing.

15.4.2. By Facsimile

A request for reconsideration submitted by facsimile transmission (fax) is considered filed on the date the fax is received by the contractor.

15.4.3. By Electronic Mail

A request for reconsideration submitted by electronic mail (e-mail) is considered filed on the date the e-mail is received by the contractor.

15.5. Must State The Issue In Dispute And Include Previous Determination

The request should state the specific issue in dispute and be accompanied by a copy of the previous denial determination notice. If a contractor receives a request for reconsideration which otherwise satisfies the requirements as stated above, the request shall be accepted notwithstanding the failure of the appealing party to provide a copy of the previous denial determination notice or to state the specific issue in dispute. In such cases, the contractor shall accept the request for reconsideration and shall supply a copy of the previous denial determination notice from its files or shall initiate communication with the appealing party to clarify the specific issue in dispute, as appropriate.

16.0. EXTENSION OF APPEAL FILING DEADLINE

If the appeal is untimely the appealing party shall be told that if it can be shown to the satisfaction of the contractor, that timely filing of the request was not possible due to extraordinary circumstances over which the appealing party had no practical control, an extension of the appeal filing deadline may be granted. A determination by the contractor that extraordinary circumstances do not exist is not appealable.

16.1. Extraordinary Circumstances Are Limited To:

16.1.1. Administrative Error

16.1.1.1. Administrative error (misrepresentation, mistake or other accountable action) of an employee of the contractor performing functions under TRICARE and acting within the scope of that individual's authority. For example, an administrative error would occur when a request for reconsideration was filed with the contractor after the expiration of the appeal filing deadline but the envelope containing the reconsideration request was misplaced by the contractor. In such a case, the misplacement of the envelope by the contractor would constitute an extraordinary circumstance over which the appealing party had no practical control, thereby permitting late filing of the appeal, unless it could be determined that:

- The appealing party used a means other than the United States Postal Service to deliver the reconsideration request to the contractor, or
- The letter requesting the reconsideration was dated after the reconsideration filing deadline, or
- Other circumstances would lead to the conclusion that the reconsideration request could not have been postmarked on or before the reconsideration filing deadline (for example, the reconsideration request was received by the contractor 30 days after the reconsideration filing deadline).

16.1.2. Mental Competence

Mental incompetence of the appealing party (this includes the inability to communicate as a result of physical disabilities).

16.2. Requests For Extension

There must have been a denial of an appeal, due to lack of timely filing, before an extension can be considered. The contractor shall return all requests for extension of the appeals filing deadline to the requesting party if an appeal has not been denied due to lack of timely filing. The contractor shall inform the requesting party that the request for extension may not be considered until a request for reconsideration has been received.

17.0. RECEIPT AND CONTROL OF APPEALS

17.1. Date Stamp

All reconsideration requests shall be stamped with the actual date of receipt within three workdays of receipt by the contractor.

17.2. Control

The contractor shall establish a single centralized appeals department and establish and maintain a single automated system for the control, location, and aging of appeals received. Appeals may be processed at more than one location but all appeals shall be managed and controlled by the centralized appeals department. The contractor's ability to respond to inquiries on a timely basis shall be measured from the actual date of receipt of the inquiry by the contractor, rather than from the date the inquiry was received in the appropriate responding department or from the date the inquiry was imaged by the contractor. The contractor is responsible for ensuring issuance of complete and accurate determinations on all reconsiderations within the time frames set forth herein.

17.3. Acknowledgment Of Receipt Of Request For Reconsideration

The contractor shall provide an interim written response for all reconsiderations not processed to completion by the date required, advising the appealing party of the estimated date of issuance of the reconsideration determination. A preprinted postcard may be used if information covered by the Privacy Act is not disclosed. Electronic mail may be used to respond to the appealing party, provided the contractor first obtains written permission from the appealing party to use electronic mail for communicating information regarding his or her appeal.

17.4. Timeliness Standards

17.4.1. General

This attachment includes standards relating to timely issuance of reconsideration determinations and timely submission of appeal case files to the NQMC and to the Appeals and Hearings Division. Standards are expressed in either calendar days or working days. To determine whether timeliness has been met relating to a standard expressed in working days, the first working day following receipt by the contractor of the request for reconsideration, or request for the appeal file, is counted as day one of the timeliness requirement. To determine whether timeliness has been met relating to a standard expressed in calendar days, the first calendar day following receipt by the contractor of the request for reconsideration is counted as day one of the timeliness requirement.

17.4.2. Timing of the Reconsideration Determination

17.4.2.1. 75% of requests for reconsideration shall be process to completion within ten working days after the date of receipt by the contractor.

17.4.2.2. 100% of requests for reconsideration shall be processed to completion within 25 working days after the date of receipt by the contractor.

18.0. RECONSIDERATION REVIEWER QUALIFICATIONS AND ADMINISTRATIVE REQUIREMENTS

18.1. Reviewer Qualifications

A reconsideration reviewer must be a qualified clinical pharmacist, or a licensed doctor of medicine or osteopathy, who is not the individual who made the initial denial determination. Exception: A reconsideration determination fully overturning the initial denial determination can be made by the reviewer who issued the initial denial determination.

18.2. Administrative Requirements

Each review shall be dated and include the signature, legibly printed name, clinical specialty, and credentials of the reviewer. Each reviewer shall include rationale for his or her decision (i.e., a complete statement of the evidence and the reasons for the decision). In addition, the name and title of the individual issuing the reconsideration determination shall be included in the Appeal Summary Log (Addendum A, Figure A-2). If the appeal file is forwarded to TMA, a completed "Professional Qualifications" form (Addendum A, Figure A-3) must be included in the file for each reviewer.

18.3. Additional Documentation

The contractor shall request and make every reasonable effort to obtain any documentation required to arrive at a proper reconsideration determination. This includes follow-up letters or documented telephone calls if requested information is not received. Whenever records are required, the contractor shall request such records directly from the provider. Written or verbal statements made by beneficiaries regarding their medical conditions are not a substitute for medical records. If there are no extenuating circumstances alleged and no added information furnished or referenced, the contractor may make the determination on the information available in its records. Improperly developed or incomplete appeal files received by TMA may be returned to the contractor for additional development, completion, and, if appropriate, issuance of a revised reconsideration determination. Due to the time constraints involved in expedited appeals, fully documenting a case file may not be possible.

18.4. File Documentation (In Other Than Provider Termination Cases)

The contractor shall carefully review the initial determination and all pertinent evidence and documentation obtained at reconsideration in light of the applicable provisions of 32 CFR 199, the Policy Manual, and all other relevant guidelines and instructions issued by TMA. The reconsideration determination shall be based on the facts of the case as shown in

the evidence and shall be supported by appropriate citations from 32 CFR 199, which shall be cited and quoted in the reconsideration determination.

18.5. File Content, Requirements, And Structure

18.5.1. The contractor shall document all determinations made at the reconsideration level in sufficient detail so that, if the next level of appeal is pursued, a subsequent reviewer shall be provided with a clear and complete picture of all actions taken on the case to that point. All material related to the reconsideration shall be made part of the permanent claim file. The copy of the appeal file provided by the contractor to the NQMC or TMA must be complete, including the Appeal Summary Log (Addendum A, Figure A-2) and the Professional Qualifications form (Addendum A, Figure A-3).

18.5.2. The contractor shall retain and completely document the file or files for all claims involved in the appeal. The contractor can either establish a separate appeal file containing all documents related to the appeal, or can gather all documents related to the appeal, including the completed Appeal Summary Log and Professional Qualifications Statement, into an appeal file when the file is requested by the NQMC or TMA. Irrespective of the method, the contractor shall be responsible for furnishing the required appeal file to the entity performing the next level of appeal within required time periods, if an appeal request is filed. The contractor is not required to submit to the NQMC, the professional qualifications of the medical reviewers referenced in paragraph 18.5.3.

18.5.3. The contractor shall organize the appeal file so that the claim(s) and initial determination(s) shall be the last section in the file and all additional documentation shall be arranged in front of it, in order of receipt. Attachments should not be separated from the transmitting document. Examples of documents that are part of the appeal file are:

- Claim(s) with attachments, including, when appropriate, all related claims,
- Initial determination(s),
- Request for Prior Authorization(s) or request for Medical Necessity review,
- Prior Authorization(s) or Medical Necessity review,
- Request for medical and / or other documentation received or obtained by the contractor prior to making the initial determination,
- Medical and / or other documentation received or obtained by the contractor prior to making the initial determination,
- Written request(s) for reconsideration, including the envelope in which it was mailed,
- Request for additional evidence submitted by the appealing party,
- Additional evidence submitted by the appealing party,

- Written and signed opinion of the reviewer(s) referenced in paragraph 18.1. above,
- Reconsideration determination(s),
- Professional qualifications of the medical reviewer(s) (see Addendum A, Figure A-3),
- Appeal Summary Log (Addendum A, Figure A-2).

18.6. File Documentation For A Provider Sanction Case

File documentation requirements in provider sanction cases shall include:

18.6.1. Initial Determination of Sanction Action as well as Proposed Notice to Sanction.

18.6.2. All correspondence and documentation relating to the sanction. Copies of the enclosures must be attached to the copy of the original correspondence.

18.6.3. Documentation that the contractor considered or relied upon in issuing a determination.

18.6.4. The completed Appeal Summary Log (Addendum A, Figure A-2).

19.0. NOTICE TO APPEALING PARTY OF RESULTS OF RECONSIDERATION

The contractor shall inform the appealing party (or the representative if a representative has been appointed) of the reconsideration determination in writing in accordance with the timeliness standards set forth in Section 4. The reconsideration determination shall be typewritten in its entirety. Handwritten notices shall not be sent. At the request of the appealing party, a reconsideration determination may be sent by facsimile transmission (fax) or by electronic mail (e-mail), followed by mailing of the determination by means of the United States Postal Service. All related claims shall be addressed in a single reconsideration determination. The notice shall include a caption identifying the beneficiary, the beneficiary's date of birth, the sponsor, the sponsor's social security number, the pharmaceutical or supply in dispute, the date(s) the pharmaceutical or supply was dispensed, the pharmaceutical or supply dispensing date(s) in dispute, whether the appeal was processed as a prior authorization or medical necessity review; and the pharmacy (identifying each pharmacy as network or non-network). The notice shall include the following headings:

19.1. Statement Of Issues

The contractor shall summarize the issue or issues under appeal and shall be clear and concise. All issues shall be addressed; for example, a reconsideration determination in all cases requiring prior authorization shall address the requirement for prior authorization of the pharmaceutical or supply as well as whether the requirement was met.

19.2. Applicable Authority

The contractor shall briefly discuss the provision of law, regulation, TRICARE policy or TRICARE guidelines on which the determination was made. Include pertinent specific citations and quotations of applicable text. The contractor should omit authority that is not applicable to the case under review.

19.3. Discussion

The contractor shall discuss the original and any added information relevant to the issue(s) under appeal, clearly and concisely, and shall state the patient's condition, including symptoms. Usually one or two paragraphs will suffice unless the issues are complex. The contractor shall include a discussion of any secondary issues raised by the appealing party or which may have been discovered during the reconsideration process.

19.4. Decision

The contractor shall state the decision and whether the reconsideration upholds or reverses the original decision in whole or in part, and clearly and concisely state the rationale for the decision; i.e., fully state the reasons that were the basis for the approval or denial of TRICARE benefits. If applicable TRICARE criteria must be met, the patient's medical condition must be related to each criterion and a finding made concerning whether each criterion is met. The contractor shall state the amount in dispute remaining as a result of the decision and how the amount in dispute was determined (calculated). Also state whether payments are to be recouped.

19.5. Appeal Rights

The contractor shall state whether further appeal rights are available if the determination is less than fully favorable.

19.5.1. Medical Necessity Contractor Reconsideration Determinations

If the contractor reconsideration determination is less than fully favorable, the contractor shall include a statement explaining the right of the beneficiary (or representative) to request an appeal to the NQMC for a second reconsideration. The statement shall inform the beneficiary (or representative) that the request for second reconsideration must be filed with the NQMC within 90 calendar days after the date of the contractor's reconsideration determination.

19.5.2. Factual (Coverage) Reconsideration Determination

If the reconsideration is less than fully favorable and $50 or more remains in dispute, the contractor shall include a statement explaining the rights of the beneficiary (or representative) to request a formal review with TMA. A request for formal review must be postmarked or received by TMA within 60 calendar days from the date of the notice of the reconsideration determination issued by the contractor.

19.5.3. When the Amount Required to File an Appeal Remains in Dispute

The following wording is suggested if the amount required to file an appeal remains in dispute. (See Section 2, paragraph 4.0. for required amount in dispute):

> "An appropriate appealing party (i.e., the TRICARE beneficiary), or the appointed representative, has the right to request a (insert level of appeal). The request must be in writing, be signed, and postmarked or received by (insert the NQMC name, postal address, e-mail address, and fax number or the Appeals and Hearings Division, TMA, 16401 East Centretech Parkway, Aurora, Colorado 80011-9066), within (insert number of calendar or working) days from the date of this decision and must include a copy of this reconsideration determination. For the purposes of TRICARE, a postmark is a cancellation mark issued by the United States Postal Service.
>
> Additional documentation in support of the appeal may be submitted. However, because a request for (insert level of appeal) must be postmarked or received within (insert number) days from the date of the reconsideration determination, a request for (insert level of appeal) should not be delayed pending the acquisition of any additional documentation. If additional documentation is to be submitted at a later date, the letter requesting the (insert level of appeal) must include a statement that additional documentation will be submitted and the expected date of submission.
>
> Upon receiving your request, all TRICARE claims related to the entire course of treatment will be reviewed."

19.5.4. Amount In Dispute Less Than The Amount Required To Accept a Request for Formal Review

For those cases in which the amount in dispute is less than the amount required to accept a request for formal review (refer to Section 2, paragraph 4.0. for Required Amount in Dispute), the contractor shall notify the appealing party or representative that the reconsideration determination is final and no further administrative appeal is available. The following is suggested wording:

> "Because the amount in dispute is less than $50.00, this reconsideration determination is final and there are no further appeal rights available."

20.0. EFFECT OF THE RECONSIDERATION DETERMINATION

20.1. The reconsideration determination is final and binding upon all parties unless:

20.1.1. The amount in dispute meets the jurisdictional requirements required to file an appeal (Refer to Section 2, paragraphs 3.3. and 4.0. regarding requirements for an amount in dispute), appeal rights were offered in the notice of denial at the reconsideration level, and a

request for a NQMC second reconsideration, formal review, or hearing, as applicable, is either postmarked or received by the appeal filing deadline, or

20.1.2. The contractor's reconsideration decision is reopened and revised by the contractor, either on its own motion or at the request of a party, within one year from the date of the reconsideration determination, or

20.1.3. The contractor's reconsideration is reopened and revised by the contractor, after one year but within four years, because: new and material evidence is received; a clerical error in the reconsideration determination is discovered; the contractor erred in an interpretation or application of TRICARE coverage policy; or an error is apparent on the face of the evidence upon which the reconsideration determination was based, or

20.1.4. The contractor's reconsideration is reopened and revised by the contractor at any time, if the reconsideration determination was obtained through fraud or an abusive practice, e.g., describing the pharmaceutical or supply in such a way that a wrong conclusion is reached; or

20.1.5. The contractor's reconsideration is reversed upon appeal at a hearing.

20.2. Further appeal of a prior authorization denial to the hearing level is not permitted unless the requested pharmaceuticals or supplies have been dispensed. An appeal to a hearing where the pharmaceuticals or supplies have been dispensed is not allowed because there would not be an adequate remedy should the hearing final decision hold in favor of the beneficiary. This is because the issue at hearing would be whether the medical documentation at the time of the request for prior authorization demonstrated medical necessity for the pharmaceutical or supply requested. A final decision issued as a result of the hearing process (which may take several months to complete) holding that the beneficiary met the requirements for prior authorization on the date the prior authorization request was made could not be implemented as the circumstances that warranted the pharmaceutical or supply at the time of the initial request would unquestionably have changed.

21.0. CASES RETURNED WITHOUT TMA REVIEW

At the discretion of TMA, certain cases appealed may be returned to the contractor for processing without the issuance of a formal review or hearing decision. These cases will normally involve instances in which a processing error has resulted in a denial or partial denial of a claim; instances in which the contractor has failed to obtain additional documentation as required by paragraph 18.3. above; instances in which the contractor has failed to address the entire episode of care; instances in which the contractor has erroneously identified a medical necessity issue as a factual issue and visa-versa; and instances in which the contractor has failed to offer appropriate appeal rights. Also, TMA, in doing normal development associated with the appeal process, may obtain information that resolves the issues without further review by TMA. If the case is returned for reprocessing, for record purposes the case will be treated as a new request for reconsideration and the returned case will be reported for workload purposes as if a new request for reconsideration was received. Development for additional documentation, if necessary, will be performed as it would in any reconsideration case. The contractor shall issue a revised reconsideration determination

based on the merits of the claim. If applicable, additional appeal rights shall be offered by the contractor.

22.0. RECORD OF RECONSIDERATION

The contractor shall ensure maintenance of records incorporating the following requirements:

22.1. The contractor shall maintain the record of its reconsideration determinations in accordance with the requirements of Attachment 13, Records Management.

22.2. The record of the reconsideration shall include:

- The initial determination.
- The basis for the initial determination.
- Documentation of the date of receipt of the request for reconsideration (include the envelope in which the request for reconsideration was received if the request was made by letter posted with the United States Postal Service).
- Record(s) of telephone contacts with provider(s).
- Evidence submitted by the parties or obtained by the contractor.
- Legible dated copies of medical (Peer) reviews with accompanying "professional qualifications" forms.
- A copy of the notice of the reconsideration determination that was provided to the parties.
- Documentation of the delivery or mailing and, if appropriate, the receipt of the notice of the reconsideration determination by the parties.
- Claim forms (when submitted).
- Appeal Summary Log.
- Request for prior authorization.
- Response to request for prior authorization.

23.0. CONTRACTOR PARTICIPATION IN THE FORMAL REVIEW AND HEARING

23.1. Contractor participation in the formal review and hearing is limited to submission of written documentation to TMA to be considered in the adjudication of the appeal. TMA will notify the contractor, by requesting the contractor's appeal file, when a request for formal review or hearing is received. The contractor shall advise TMA within ten calendar days of receiving notification that a formal review or hearing request has been received, that it intends to participate in the formal review or hearing through submission of additional

documentation. The additional documentation shall be received by TMA within 20 calendar days following the notice to the contractor of the receipt of the formal review or hearing request.

23.2. The contractor may appear at the hearing as a witness and offer testimony in such capacity. TMA will notify the contractor when a request for hearing is received by requesting the contractor's appeal file. The contractor shall advise TMA, within ten calendar days of receiving notification that a hearing request has been received, that it intends to appear at the hearing as a witness. If the contractor has advised TMA that it intends to appear at the hearing as a witness, TMA will advise the contractor of the time and place of the hearing.

23.3. If, after receiving notice from TMA that a formal review or hearing request has been submitted, the contractor receives additional claims or documentation related to the formal review or hearing, the contractor shall notify TMA of the receipt of the additional claims or documentation and submit copies of the claims or documentation to TMA, as well as copies of any written response the contractor may have issued resulting from the receipt of additional claims or documentation.

SECTION 4

TMA APPEALS

24.0. RESPONSIBILITIES AND PROCEDURES

24.1. Assistance To Beneficiaries

The contractor shall provide beneficiaries, or other qualified persons requiring assistance, with information needed for proper filing of a request for formal review or hearing. Such assistance shall include advising of requirements for timely filing, the amounts in dispute required for filing the request, the specific matter in dispute, copies of the written determination notice(s) which is (are) being appealed, and any additional documents and/or information which may have a bearing on the matter in dispute.

24.2. Assistance To TMA

24.2.1. When TMA receives a request for a formal review or hearing, the contractor will be requested to furnish the complete file(s) covering the claim(s) and reconsideration(s) in dispute. (See Section 3, paragraph 4.5 for requirements.) The TMA Appeals and Hearings Division will request the entire appeal file by telephone or facsimile transmission (fax). The contractor will also provide copies of non-proprietary information contained in its agreements with network providers involved in the formal review or hearing case if requested to do so by the TMA Appeals and Hearings Division. The contractor shall copy the entire file (making one-sided copies only) and mail it by express mail to the TMA Appeals and Hearings Division, as soon as possible.

24.2.2. In no case shall the mailing of the file occur later than five workdays after receipt of the telephone call or fax request. In addition, upon request, the contractor shall assist TMA in developing additional information as may be necessary to fully develop facts in the case. To facilitate communications between TMA and the contractor, the names of specific persons in the centralized appeal unit who are responsible for coordination of appeal functions shall be furnished to the TMA Appeals and Hearings Division and the NQMC by the contractor. Names and phone numbers shall be updated as necessary and notice provided.

24.3. Assistance To Incoming Contractor, NQMC, And TMA During Transition

In the event of a transition, the outgoing contractor shall make available, upon request, individual cases completed during the transition period and not yet transferred to the incoming contractor or NQMC. In no case shall mailing the appeal file to the incoming contractor, the NQMC or TMA occur later than five workdays after receipt of a telephonic, written or fax request from TMA or the incoming contractor during a transition period.

25.0. QUESTIONS REGARDING APPEALS

Written inquiries received by a contractor regarding an appeal which is at the TMA level shall be forwarded to TMA Appeals and Hearings Division, 16401 E. Centretech

Parkway, Aurora, Colorado 80011-9066, for response. The contractor shall inform the appealing party or representative that the case has been forwarded to TMA for review and shall advise the appealing party to address his or her questions to the Appeals and Hearings Division, TMA, 16401 E. Centretech Parkway, Aurora, Colorado 80011-9066.

26.0. CONTRACTOR DETERMINATIONS REVERSED BY THE APPEAL PROCESS

The contractor shall reprocess all determinations reversed by a formal review determination or hearing final decision in accordance with the standards set forth herein. For the purposes of assessing timeliness, the date of receipt is considered the date the formal review determination or hearing final decision is received by the contractor.

ADDENDUM A

FIGURES

FIGURE A-1 APPOINTMENT OF REPRESENTATIVE AND AUTHORIZATION TO DISCLOSE INFORMATION

(Reproduce Locally)

SAMPLE FORMAT

I appoint *(Print/Type Name and Address of Representative)* to act as my representative in connection with my appeal under 32 CFR 199.10, Appeal and Hearing Procedures. To avoid the possibility of a conflict of interest, I understand that an officer or employee of the United States, to include an employee or member of a Uniformed Service, an employee of a Uniformed Service legal office, an MTF Provider or a Health Benefits Advisor, is not eligible to serve as a representative. An exception to this is made when an employee of the United States or member of a Uniformed Service is representing an immediate family member.

I authorize the TRICARE Management Activity (TMA) to release to said representative, information related to my medical treatment, and if necessary, photocopies of any medical records which may be required for adjudication of my claim for TRICARE benefits.

I understand that the representative shall have the same authority as the party to the appeal and notice given to the representative shall constitute notice to the party.

This consent will expire upon the issuance of the final agency decision regarding my appeal; however, I reserve the right to withdraw this authorization at any time.

_____

(Date) *(Signature of Person Giving Consent)*

Prohibition on redisclosure:

Further disclosure of information by the appointed representative may only be made in accordance with the provisions of the Privacy Act of 1974 and other applicable Federal law.

FIGURE A-2 APPEAL SUMMARY LOG, TMA FORM 607

PART I. TO BE COMPLETED BY TRRx CONTRACTOR

APPEALING PARTY	CONTRACTOR'S IDENTIFICATION NO.	DATE PREPARED

❑ PROVIDER ❑ BENEFICIARY ❑ REPRESENTATIVE	BENEFICIARY	DATE OF BIRTH

APPEALING PARTY'S ADDRESS

SPONSOR	SPONSOR SSN	REPRESATIVE'S NAME (IF APPLICABLE)

❑ ACTIVE DUTY ❑ RETIRED ❑ DECEASED	BENEFICIARY'S RELATIONSHIP TO SPONSOR

PROVIDER'S INFORMATION (LIST ADDITIONAL PROVIDERS IN COMMENT SECTION)
NAME(S) (ALL PROVIDERS)

1.	❑ NON-NETWORK	❑ NETWORK
2.	❑ NON-NETWORK	❑ NETWORK
3.	❑ NON-NETWORK	❑ NETWORK
4.	❑ NON-NETWORK	❑ NETWORK
5.	❑ NON-NETWORK	❑ NETWORK

YES	NO		
		MEDICAL NECESSITY DETERMINATION ❑	FACTUAL DETERMINATION ❑
❑	❑	PROPER APPEALING PARTY?	
❑	❑	BENEFICIARY ELIGIBILITY ESTABLISHED?	
❑	❑	DOUBLE COVERAGE? (IF YES, NAME OF OTHER PLAN)	_____
❑	❑	MEDICAID COVERAGE?	
❑	❑	PARTICIPATING PROVIDER? (IF NON-NETWORK)	
❑	❑	TIMELY FILED? (IF YES, DATE MAILED/RECEIVED)	_____

AMOUNT IN DISPUTE DATE (IF ADDITIONAL CLAIMS, LIST ON ADDITIONAL SHEETS)
(See reverse for instructions)

							AMOUNT PAID BY		
Date of Service	(a) Initial Determination Date	(b) ICN(s) of Claims Appealed	(c) Billed Charges	(d) Allowable Charges	(e) Amount Denied	(f) Deductible Amount	(g) Other INS	(h) TRICARE	(i) Cost Share

Comments (Identify Service):

Retail Pharmacy Contractor Point of Contact:

PART II. TO BE COMPLETED BY NATIONAL QUALITY MONITOR CONTRACTOR (IF APPLICABLE)

SECOND RECONSIDERATION DETERMINATION:

YES	NO		
❑	❑	PROPER APPEALING PARTY?	
❑	❑	TIMELY FILED? (IF YES, DATE MAILED/RECEIVED)	_____
❑	❑	AMOUNT IN DISPUTE REMAINS $300 OR MORE?	

NQMC Point of Contact:	DATE PREPARED

TMA FORM 607
REV. JAN. 98

FIGURE A-2 APPEAL SUMMARY LOG, TMA FORM 607 (CONTINUED)

PREPARATION OF AMOUNT IN DISPUTE DATA

a.	Initial determination date	Enter date of the initial determination, which is usually the TRICARE Explanation of Benefits (EOB) date.
b.	ICN(s) of claims appealed	Enter the ICN of each claim being appealed.
c.	Billed charges	Enter total amount billed for this (these) claim(s).
d.	Allowable charges	Enter total allowable amount. For purposes of determining "amount in dispute," include the amount which would have been "allowable" if the pharmaceutical or supply denied would have been payable.
e.	Amount denied	Enter the amount of the "allowable charges," which were denied. Do not include any "allowable charge" reductions.
f.	Deductible amount	Enter amount of deductible, if any, applied to this (these) claim(s).
g.	Amount paid by other insurance	Enter amount of other insurance payment applicable.
h.	Amount paid by TRICARE	Enter amount actually paid by TRICARE on this (these) claim(s).
i.	Amount paid by cost share	Enter amount actually to be paid by the beneficiary / sponsor. If other insurance covers the entire cost share, enter 0.

FIGURE A-3 PROFESSIONAL QUALIFICATIONS, TMA FORM 780

Form Approved
OMB No.: 0720-0005
Expires: 31 Aug 03

PROFESSIONAL QUALIFICATIONS
MEDICAL/PEER REVIEWERS

The Public reporting burden for this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports (0720-0005), 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

Privacy Act Statement

AUTHORITY:	10 U.S.C. 1079, 1086 and 1092
PRINCIPAL PURPOSE:	To solicit the professional qualifications of medical specialists and their credentials for Medical/Peer Reviewers positions. Individuals selected will review medical documentation contained in appeal or hearing case files.
ROUTINE USE:	None
DISCLOSURE:	Voluntary. No effect on respondents for not providing requested information.

Physician's/Reviewer's Name:	Year of Birth:
Address:	

Medical Education

State:	Year of Degree:
School:	Year of License:
American Specialty Boards:	
Specialties:	
Type of Practice:	
National Scientific Medical Societies:	

CHAMPUS Form 780
February 2002

Previous editions are obsolete

FIGURE A-3 PROFESSIONAL QUALIFICATIONS, TMA FORM 780 (CONTINUED)

Professional Appointments		
State:	School:	
Title and Current Status:		
Other Information:		
Sources of Information (Professional Listing)		
Name of Directory:		
Year:	Edition:	Page:
Other Sources:		

CHAMPUS Form 780
February 2002

Previous editions are obsolete

FIGURE A-4 LETTER TO PROPER APPEALING PARTY WHEN REVIEW HAS BEEN REQUESTED BY AN IMPROPER APPEALING PARTY

An appeal in your behalf has been received from *(Name of Person who requested Appeal)*. Under 32 CFR 199.10, *(Name of Person)*, is not an appropriate appealing party, and, consequently, the request cannot be accepted as an appeal.

The TRICARE case file does not indicate that you have appointed anyone as representative to act in your behalf. Therefore, if you wish to appeal you have the following options:

a. Appeal in your behalf.

b. Appoint a representative who may request an appeal in your behalf.

If you intend to appeal in your own behalf or through a duly-appointed representative, the appeal must be received within 20 days of the date of this letter or by the appeal deadline set forth in the initial determination notice (whichever is later).

An Appointment of Representative form is enclosed for your convenience should you wish to appoint a representative. Your correspondence should be addressed to:

(Contractor's Name And Address)

Signature

cc:
Improper Appealing Party

FIGURE A-5 TRICARE APPEALS PROCESS - MEDICAL NECESSITY DENIALS

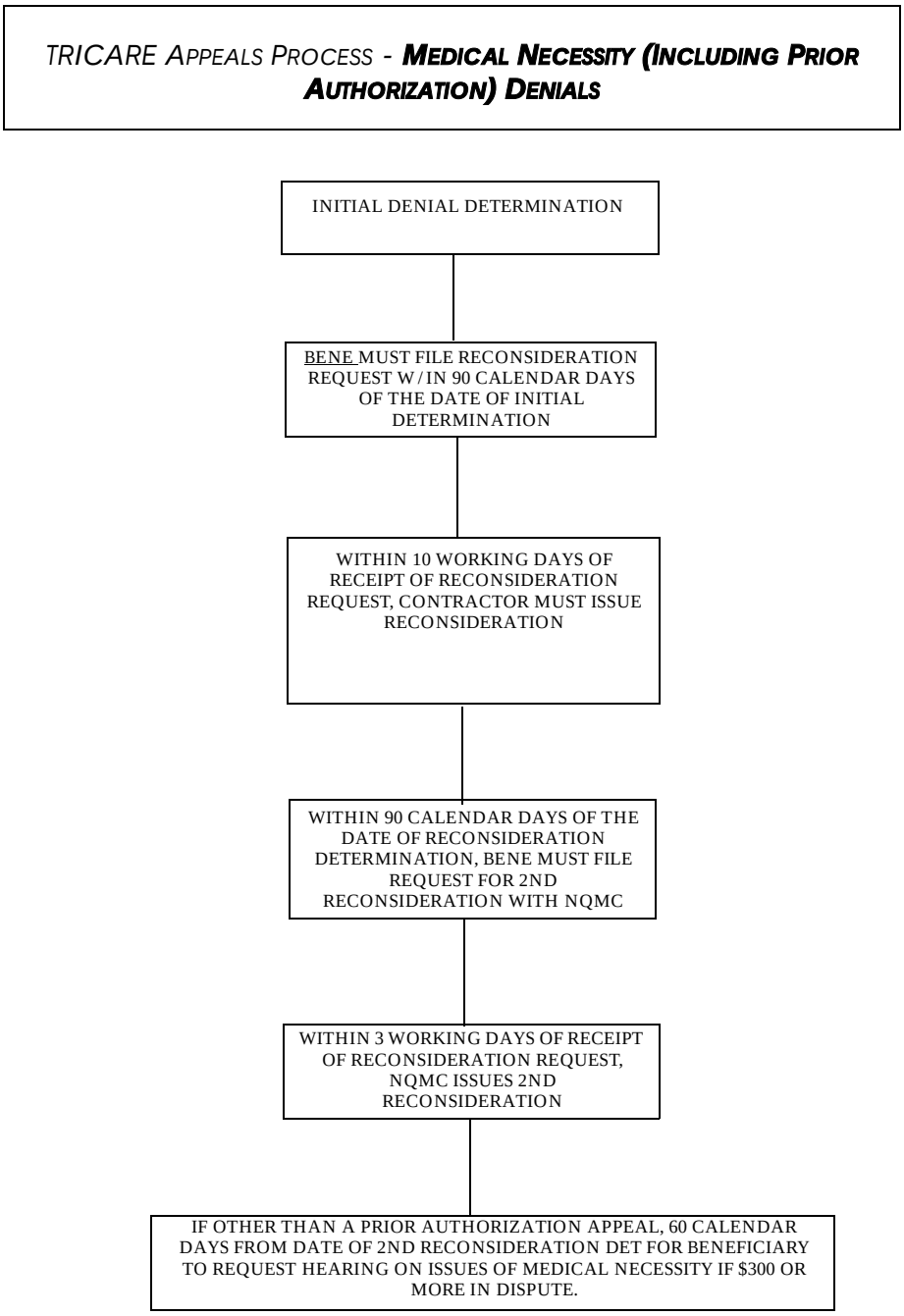

FIGURE A-6 TRICARE APPEALS PROCESS - FACTUAL DETERMINATIONS